Violence Code Reload

Ft. Lauderdale hospital launches successful new violence prevention program

Health care workers endure more than long shifts, strenuous responsibilities, and hectic schedules. Statistics show that they're also particularly vulnerable to harm from aggressive outbursts by patients.

Studies indicate that anywhere from 35% to 80% of hospital staff have been physically assaulted at least once during their careers.[1] In fact, in 2011, the incidence rate for violence and other injuries for health care/social assistance workers (15 per 10,000 full-time workers) was more than triple the overall rate for all of private industry (4 per 10,000 full-time workers).[2]

Health care organizations can decrease the risk of violence by doing the following:

- Establishing policies for how health care workers should respond to aggressive behavior
- Having appropriately trained personnel
- Instituting de-escalation and violence management practices

All these important steps were at the forefront for Pat Schuldenfrei, EdD, RN, director of patient safety and clinical performance improvement for Holy Cross Hospital in Ft. Lauderdale, Florida. After seeing some nurses sustain injuries such as black eyes, bloody lips, and bites inflicted by aggressive patients, she knew it was time for significant changes.

So in late 2012, Schuldenfrei and hospital director of security Darren DeBolt created the Task Force for the Prevention of Patient Violence and outlined a violence prevention program that called for major upgrades to current response procedures.

Taking threats seriously

In the past, Holy Cross staff had often tolerated verbal abuse from patients without involving security personnel. A physically threatening individual, however, would warrant a "Code Strong" which involved staff paging security for immediate assistance. The process was not consistent, though—often, not enough security officers would arrive.

"Our nurses had little guidance on this issue and at times were afraid for their safety," says Schuldenfrei, one of up to 1,000 nurses at Holy Cross, which has 559 beds and more than 3,000 employees.[3] "The tipping point came when I was visiting a patient who was lightly restrained but potentially violent. Here was a 250-pound, big, strong guy with an older nurse's aide at the foot of his bed. I asked her, 'What if he breaks free and attacks you—what are you going to do?' She admitted that she did not know."

Schuldenfrei and DeBolt realized that the changes to be suggested would involve the expenditure of hospital resources and require the support of hospital administration. They invited Meg Scheaffel, RN, the hospital's chief nursing officer; William Korey, MD, an emergency department physician; and several other key players to join their task force. Working together, the group hammered out the blueprint for what became Holy Cross' current program, which launched in late 2012 and included revamped polices, new response protocol, additional training, and targeted communications.

Codes for help

To manage violence hazards quickly and effectively, the task force implemented a new system involving the following three levels of security codes:

- **Security Level 1—Code Assist:** This code is paged when a patient or visitor becomes verbally abusive and/or begins to act defiantly without being physically violent. In response, one uniformed security officer is immediately dispatched to the site.
- **Security Level 2—Code Strong:** This is a new and improved code that summons a team of trained first responders, including security officers, the nurse supervisor, and male hospital engineers trained to drop what they're doing and help. Typically, a Code Strong offender is both physically and verbally aggressive and presents a serious safety risk to him/herself and those nearby.
- **Security Level 3—Code Strong with Intensive Care Physician:** This code can only be called by a registered nurse (RN). It involves the same response as a Code Strong but also summons a physician, who is authorized to order the sedation sometimes required to subdue an out-of-control patient.

Trio of training levels

For violence prevention to be effective, staff need to be carefully educated about how to identify and respond to hostile threats. Consequently, the task force also developed the following three-tiered training program:

- **Tier 1 training:** This requires every hospital employee to complete a one-hour online class that covers the general

A Tale of Two Patients

The positive impact that Holy Cross's violence prevention program has made can be demonstrated by two similar incidents—one that occurred prior to the program rollout (in 2012), and one after (in 2013).

Before the rollout: A homeless alcoholic is admitted to the medical surgical unit. He acts belligerently—throwing punches, thrashing about, and screaming. The nurse calls a Code Strong, which summons two security guards who are unsure if they are allowed to physically restrain the patient. The patient screams for 30 minutes while the nurse calls his physician for orders.

After the rollout: A different homeless alcoholic is admitted to the medical surgical unit. Recognizing impending delirium tremens based on the new assessment tool she uses, the nurse immediately requests an alcohol detoxification protocol from the attending physician. However, the patient grows increasingly aggressive—flailing about and being verbally abusive. The nurse calls a Code Strong with Intensive Care Physician, and five well-trained staff, including security officers, a nurse supervisor, and hospital engineers, arrive to restrain the patient. Moments later, the intensive care physician authorizes additional medication, and the situation is quietly resolved within 15 minutes.

topic of workplace violence prevention.

• **Tier 2 training:** This obligates all clinical staff to complete two hours of live classroom continuing education, which addresses topics like violence awareness and prevention, de-escalation techniques, and personal safety best practices. These techniques include effective blocking of punches and kicks; freeing oneself from grabs, choke holds, hair pulls, and bites; and maintaining a safe personal space buffer of 3 to 6 feet from a patient if a caregiver feels threatened.

• **Tier 3 training:** ED staff, nurse supervisors, security personnel, and engineers are mandated to complete tier 3, which consists of eight hours of nonviolent crisis intervention training. In addition to the techniques covered in tier 2, attendees learn more advanced techniques to protect themselves and patients—including team intervention for control and restraint. They also learn what it takes to be a member of the code response team, which involves collaborating with two to five other members to safely control and restrain an out-of-control individual. In addition, they practice giving and taking commands, ensuring that the environ-ment is safe (dispersing crowds, moving furniture, opening doors), communicating with the potentially violent individual, and providing a safe environment during a crisis.

All hospital classes employ the methodology of nonviolent crisis intervention training, DeBolt says.

Other safety steps

Holy Cross didn't stop there. It took more steps to help prevent violence.

Incorporating violence drills. The hospital also began incorporating violence-themed situations in its security drills. For instance, in June the organization hosted an "active shooter" scenario in which a vest-clad security officer, portraying an out-of-control gunman on the loose in the hospital, attempted to hunt down employees spread across different floors and hallways. Any worker spotted by the gunman was considered a casualty.

"That drill was a great success, even though it was the first time we'd ever conducted a scenario of that kind," says DeBolt, who adds that other crisis intervention drills are practiced throughout the year so that staff learn how and when to call a Code Strong versus a Code Assist. "This was the first of many 'active shooter' drills that we will be practicing. The objective was to teach staff basic principles to apply during a real-life event. As we move forward, we will incorporate how we will best protect patients, visitors, and others in the facility."

Providing panic buttons. To better protect those who may be assigned close observation of dangerous patients, the hospital equipped nurse's aides with panic buttons that, when activated, emit a 130-decibel screeching distress siren.

Sharing best practices. Holy Cross created a series of helpful signs, posters, and checklists that reinforce violence prevention policies and procedures. Schuldenfrei and several peers are also preparing to share these best practices in a forthcoming nursing journal article and will present a poster outlining their model at an upcoming nursing conference.

Meeting high standards

Holy Cross's violence prevention program was carefully designed to incorporate and address several Joint Commission Standards, including the following: Environment of Care Standards EC.01.01.01, "the hospital plans activities to minimize risks in the environment of care," and EC.02.01.01, "the hospital manages safety and security risks"; plus Emergency Management Standard EM.02.02.05, "as part of its emergency operations plan, the hospital prepares for how it will manage security and safety during an emergency."

"Abiding by Joint Commission standards is essential for an accredited hospital like ours," says DeBolt. "Instituting this violence prevention program shows that we're being proactive and trying to provide a safe environment to patients, visitors, and staff."

Violence Code Reload
(continued from page 7)

Reading between the numbers

Before implementing its new violence prevention program, Holy Cross set a goal of reducing Code Strong incidents by 25% in 2013. Despite a rise in Code Strongs after the program started—113 in the first seven months of 2013 versus 152 total violent events recorded in 2012—Holy Cross's program has proved to be a success, says DeBolt. The spike was expected, as nurses have been more likely to call for help and report aggression since the program rollout.

"We expect Code Strong events to decease significantly over time as we're more aware of the dangers and aggressive actions in our midst," says DeBolt, who is hopeful that nurses will effectively use de-escalation techniques and Code Assists to prevent Code Strongs from occurring.

Code Strong incidents actually dropped recently from an average of 20 per month between January and May to an average of 6 during June and July. Code Assists (33 between March and July) have also decreased in recent months.

"Nurses today tell us how pleased they are that a visible effort is being made for

their safety, and the level of trust and collegiality between nursing and security is definitely better," Schuldenfrei says.

Lessons learned

The violence prevention program is a work in progress but one that continues to provide valuable learning opportunities to hospital staff.

Learning from the data. "We've learned quite a bit because we follow up on every Code Strong event. A nurse from our team will revisit a patient's chart and his caregiver within 24 hours of the incident to determine why it happened and what could have been done differently to prevent or improve the situation," says Schuldenfrei.

The data collected have helped determine the triggers of violence. Among all Code Strongs that occurred between January and July 2013, 42% were related to alcohol/drugs, 15% were related to delirium, 12% were triggered by dementia, 7% by mental illness, and 4% by hypoxia. Many who become hostile are homeless, psychotic, and/or elderly.

Learning to recognize and react. Most importantly, the program has taught vulnerable employees how to recognize and react appropriately to a volatile situation.

"Nurses have learned that the Code Assist is a valuable tool to set boundaries with persons who are verbally assaultive. The interaction with a uniformed security person sets limits. It is often enough to change behavior," says Schuldenfrei. *See* the sidebar on page 7, "A Tale of Two Patients," for a before-and-after case study of program results.

Involving security in policies and procedures. DeBolt says the hospital has benefitted by having security personnel help shape policies and procedures.

"We used to be just first responders for a Code Strong call. Now we sit on the violence prevention advisory committee and help teach the training classes," says DeBolt. **EC**

References

1. Clements PT, DeRanieri JT, Clark K, Manno MS, Wolick Kuhn D. Workplace violence and corporate policy for health care settings. *Nurs Econ.* 2005;23(3):119–124.
2. U.S. Bureau of Labor Statistics. Nonfatal occupational injuries and illnesses requiring days away from work, 2011. Accessed Aug 12, 2013. http://www.bls.gov/news.release/pdf/osh2.pdf.
3. Holy Cross Hospital. Holy Cross Hospital receives Blue Distinction Center designation for quality and efficiency. Ft. Lauderdale: Holy Cross Hospital; 2013. Accessed Aug 12, 2013. http://www.holy-cross.com/holy-cross-hospital-receives-blue-distinction-center-designation-quality-and-efficiency.

THE STATS on Hospital-Based Shootings

We all know that violence—specifically, shootings—in health care facilities is a growing problem. But exactly how big a problem? A recent study by Johns Hopkins gives some chilling facts. Using web-based tools, researchers searched reports for acute care hospital shooting events in the US. Here's what they found.

For 2000 through 2011, there were

41% outside the hospital (on hospital grounds)
23% in the parking lot

59% inside the hospital
ED: **29%**
patient rooms: **19%**

154 hospital-related shootings

235 injured or dead
45% shooter (most common)
20% employees

And perhaps most unsettling of all, in nearly 1/2 of all shootings in the ED, the weapon was a security officer's gun taken by the shooter.

Source: *Annals of Emergency Medicine*, September 2012.

On Course to Curb Workplace Violence

Free new NIOSH online class offers valuable tips and CE credits

Nurses, clinicians, and other medical staff shouldn't have to fear for their safety. And yet, research shows that providing health care can be hazardous to the caregiver's health. On average, over the past decade in statistics covering all industries, US health care workers (HCWs) sustained two-thirds of all nonfatal workplace violence injuries requiring days away from work.[1] And from 1997 to 2009, there were 130 workplace homicides in the health care and social assistance industries within the private sector.[2]
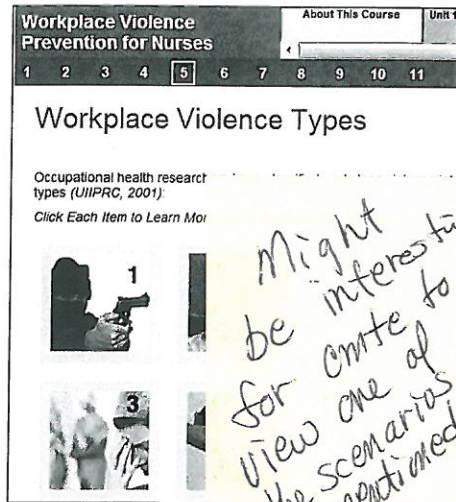
The concern over violence is so prevalent that The Joint Commission has issued two *Sentinel Event Alerts* related to the topic:

- Issue 40, "Behaviors that undermine a culture of safety"[3] (2008)
- Issue 45, "Preventing violence in the health care setting"[4] (2010)

Recognizing the increasing risks of aggression in health care environments, the National Institute for Occupational Safety and Health (NIOSH) has created a new online course entitled "Workplace Violence Prevention for Nurses" (available at http://www.cdc.gov/niosh/topics/violence/training_nurses.html). This free electronic class module meets an important need: helping HCWs identify and avoid hostility on the job.

Four years in the making

Daniel Hartley, EdD, NIOSH workplace violence prevention coordinator, Division of Safety Research, Morgantown, West Virginia, conceived of the course in 2009, with the help of Marilyn Ridenour, BSN, MBS, MPH, CPH, NIOSH nurse epidemiologist.

Workplace Violence Prevention for Nurses

1 2 3 4 [5] 6 7 8 9 10 11

Workplace Violence Types

Occupational health research types (UIIPRC, 2001):

Click Each Item to Learn Mor

The NIOSH course [...] user-friendly, interactive graphic elements that can be clicked on for more content.

[Handwritten note: Might be interesting for cmte to view one of the scenarios mentioned.]

"NIOSH has been researching workplace violence for approximately 30 years. Over the past 10 years, we have participated in several discussions with health care professionals, and one recurring theme that we noted was that many go their entire career without receiving training in workplace violence prevention," says Hartley.

Although other classes on this topic exist, Ridenour feels that the NIOSH course is unique.

"It's the only known online instructional of its kind that is gratis and offers free CE units to those who qualify," says Ridenour. "Additionally, the class covers the subject more thoroughly, having been developed by several of the leading experts in the field of workplace violence prevention for health care workers."

To develop and design the digital materials, NIOSH partnered with a Cambridge, Massachusetts–based provider of courses, programs, and e-learning materials for the health care industry—and its chief operating officer

John Craine and project manager LeeAnn Hoff, who served as lead author of NIOSH course content. In creating the curriculum, NIOSH also enlisted 30 academic researchers as well as numerous representatives from the Centers for Disease Control and Prevention, Veteran's Health Administration, American Nurses Association, and other groups.

Learning about violence— From A to Z

Separated into 13 units that each take approximately 15 minutes to complete, the course includes lesson text, videos portraying workplace violence events, testimonials from practicing nurses, eye-catching graphics, brief quizzes after each unit, and a comprehensive exam at the course conclusion.

The main goal of the course is to increase violence awareness among nurses and other HCWs. Attendees can expect to learn definitions, classifications, and risk factors for workplace violence; consequences for the employee and employer; post-event responses; and how workplace violence has affected other HCWs. The course also teaches proactive prevention strategies, such as recognizing the warning signs that precede most violent incidents and identifying methods to increase one's own safety by being attuned to personal behaviors of a potential aggressor.

Hartley says the video case studies, featuring professional actors who depict different troublesome scenarios based on real-life events, are particularly beneficial. These scenarios include a patient's family member who becomes aggressive

On Course to Curb Workplace Violence

with a nurse, a home health care patient threatening homicide, and a cognitively impaired patient who injures an HCW.

"One of the best videos is a scenario involving a psychiatric patient," says Hartley. "He has just acted out violently and is presenting some indications that he may become violent again. The patient is escorted by security to a psychiatric nurse, who speaks compassionately with him. She realizes he's stopped taking his medication. She discusses some options with him, and they determine that it's best for him to get back on his medications and stay in the facility for overnight observation."

Recorded interviews with real HCWs are also riveting. For example, one video spotlights several nurses who discuss the disturbing assaults they survived. A nurse describes an injury she sustained that permanently affected her grip, and another recounts her inability to sleep at night because of the psychological trauma her attack caused.

Graduating to the head of the class

Jane Lipscomb, RN, PhD, FAAN, professor at the University of Maryland, Baltimore, notes that the NIOSH course is far more comprehensive and educational than comparable paid classes available to hospitals and their staff. Consequently, she strongly encourages HCWs to complete the class and health care organizations to introduce it into their violence prevention programs.

"A lot of comparable commercial curricula usually focus on only three domains—early intervention, escalation of potentially violent patients, and self-defense," says Lipscomb, who was one of the expert consultants NIOSH recruited to review and revise the course materials

---

Test Your Workplace Violence Knowledge

Take this quiz, pulled from materials in the new NIOSH workplace violence course, to see how sharp you are on the subject.

1. Approximately 82% of emergency department nurses: (a) do not feel safe in the workplace; (b) have been physically assaulted at least once during their career; (c) were physically assaulted at work in one year.

2. The most common type of workplace violence in health care settings is classified as: (a) Type 1—criminal intent; (b) Type 2—patient/client/visitor; (c) Type 3—worker on worker; (d) Type 4—personal.

3. True or false: The Occupational Safety and Health Administration uses the General Duty Clause of the Occupational Safety and Health Act of 1970 as its enforcement authority regarding workplace violence.

4. An acutely distressed person is essentially out-of-control on which of the following levels: (a) cognitive, behavioral, and emotional; (b) behavioral, emotional, and biophysical; (c) biophysical, behavioral, and cognitive.

Source: Workplace Violence Prevention for Nurses. CDC Course No. WB1865 - NIOSH Pub. No. 2013-155

Answers: 1 (c); 2 (b); 3 (true); 4 (a).

---

created. "What's often missing is the way in which that training fits into the organization's overall workplace violence prevention program and how essential it is for organizations to collaborate with frontline workers to ensure that both patients and staff are safe."

Unlike many others, "this class reinforces the importance of getting commitment from top management and involvement from employees, conducting comprehensive risk assessments, and encouraging reporting of incidents and continuous quality improvement," Lipscomb says.

The NIOSH course "is worth health care professionals' time and effort because, aside from not costing anything, the techniques it teaches could not only increase your feeling of safety and satisfaction on the job but could also save your life," says Ridenour.

Lipscomb agrees, adding that completing the NIOSH course could make the difference between having a long, healthy career in the health care profession and leaving the profession prematurely out of fear or because of a work-related injury.

Extra credit incentives

"The course is aimed at prevention of violence in health care, but many of the underlying principles apply to any industry," Hartley says. He points out that anyone with Internet access can take the class, even workers in non-health care professions.

Attendees can also earn continuing education (CE) units for licensing requirements by completing the course and posttest. The Centers for Disease Control and Prevention awards 2.6 hours of CE credits to nurses, and the International Association for Continuing Education and Training awards 0.3 CE credits to any health care professional, or 2.5 category I CE credits to health education specialists.

The electronic course has no completion deadline, and bookmarking technology allows users to return at any time to the exact point they left off.

Future of the class

The NIOSH course was launched online in August. "The early feedback we've been getting from visitors and attendees

On Course to Curb Workplace Violence
(continued from page 10)

so far via e-mail, Facebook, and our blog has been overwhelmingly positive and complimentary," Hartley says. For a taste of the content and to test your own knowledge, take the sample quiz on page 10.

The NIOSH team plans to update the course content periodically and is currently working on adding occupation-specific units to it—to be rolled out in 2015—that will address workplace violence issues in emergency departments, psychiatric departments, and long term care facilities. Completing each extra unit will likely earn one additional hour of CE credits for the attendee.

"We also have future plans to address emergency first responders, home health providers, and social services workers," adds Hartley. **EC**

References
1. US Bureau of Labor Statistics. 2011. Occupational injuries/illnesses and fatal injuries profiles. http://data.bls.gov/gqt/InitialPage. Accessed Sep 10, 2013.
2. US Bureau of Labor Statistics. Homicide: Occupational homicides by selected characteristics, 1997–2010. http://www.bls.gov/iif/oshwc/cfoi/work_hom.pdf Accessed Oct 1, 2013.
3. Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert*, issue 40. Jul 9, 2008. Accessed Aug 29, 2013. http://www.jointcommission.org/assets/1/18/SEA_40.PDF.
4. Joint Commission. Preventing violence in the health care setting. *Sentinel Event Alert*, issue 45. Jun 3, 2010. Accessed Aug 29, 2013. http://www.jointcommission.org/assets/1/18/sea_45.pdf.

Test your STANDARDS IQ

The Answers

Here are the answers to the questions on page 2. How did you do?

1. **C, The name and manufacturer of the fire extinguishers used in the building.** While you may choose to include details about the equipment used to contain a fire, such as the name and manufacturer, it is not necessary. A fire response plan is your organization's emergency plan for fire safety. It describes the actions your staff and licensed independent practitioners will take when responding to a fire, outlining their roles and responsibilities at and away from the fire's point of origin. The fire plan must address both facilitywide and area-specific incidents, and it must detail how to sound the fire alarms, contain any smoke and fire, operate any fire equipment, and evacuate the area, if necessary.
   STANDARDS REFERENCE: EC.02.03.01, EP 10

2. **True.** The Joint Commission requires long term care organizations, critical access hospitals, and hospitals to consider the role of both internal security personnel and community security agencies—police, sheriff, National Guard—during an emergency and work with outside agencies to ensure the safest environment for patients and staff. Your organization's relationship with community security agencies may be quite different during an emergency than during normal business operations. Organizations should think about how the relationship will change and address it within the Emergency Operations Plan.
   For instance, you may want to review what law enforcement agents should do with their weapons when they enter your facility during an emergency. Will you allow agents to bring their weapons into the facility at all? Require agents to check weapons at the door? Limit where agents with weapons can go? If an organization does not allow law enforcement to bring weapons into the facility during normal business operations but would like to alter this policy for emergency situations, the organization should make law enforcement aware of this change in policy before the onset of an emergency.
   STANDARDS REFERENCE: EM.02.02.05, EP 2

3. **D, Every six years.** The Joint Commission requires organizations to maintain any fire safety equipment and features present in their facilities, including fire and smoke dampers. If a hospital has fire and smoke dampers in place, it must test them every six years. During this test, organizations should make sure the dampers fully close to adequately prevent the spread of smoke and fire. The completion dates of the test must be documented. For additional guidance, *see* NFPA 80, *Standard for Fire Doors and Other Opening Protectives*, 2007 edition (Section 19.4.1.1) and NFPA 105: *Standard for Smoke Door Assemblies and Other Opening Protectives*, 2007 edition (Section 6.5.2).
   STANDARDS REFERENCE: EC.02.03.05, EP 18

4. **False.** The Emergency Management (EM) standards require organizations—including critical access hospitals—to inventory their supplies for use in an emergency *every* year. This ensures that the organization is ready to continue and sustain the delivery of care, treatment, and services in the event of an emergency. Note that the findings of this review must be documented. A solid understanding of the scope and availability of your organization's resources and assets is essential at any time but is perhaps most important during an emergency, when there is no time to address shortfalls.
   STANDARDS REFERENCE: EM.03.01.01, EP 3

5. **C, Two years.** Performance and function testing are critical activities in a laboratory. The Joint Commission requires laboratories to conduct daily, weekly, monthly, quarterly, or semiannual performance tests on all instruments and equipment used in the laboratory. The time frame will vary, depending on the nature of the instrument or equipment. The results of these tests must be documented and retained for at least two years. This provides a detailed equipment performance history that can be used to evaluate future testing and use.
   STANDARDS REFERENCE: EC.02.04.03, EP 11 **EC**